local officials, to the extent that the administrative or judicial action would seek to require response action that is within the scope of the response action conducted in accordance with State and local law.

''(2) URBAN AREA DEFINED.—For purposes of paragraph (1), the term 'urban area' has the meaning given that term under section 1393(a)(3) of the Internal Revenue Code of 1986.''.

SEC. 402. BROWNFIELD PROGRAM.

Title I of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601 et seq.) is amended by adding at the end the following:

''SEC. 127. BROWNFIELD PROGRAM.

''(a) DEFINITION OF BROWNFIELD FACILITY.—In this section, the term 'brownfield facility' means—

''(1) a parcel of land that contains an abandoned, idled, or underused commercial or industrial facility, the expansion or redevelopment of which is complicated by the presence or potential presence of a hazardous substance; but

''(2) does not include—

''(A) a facility that is the subject of a removal or planned removal under this title;

''(B) a facility that is listed or has been proposed for listing on the National Priorities List or that has been removed from the National Priorities List;

''(C) a facility that is subject to corrective action under section 3004(u) or 3008(h) of the Solid Waste Disposal Act (42 U.S.C. 6924(u) or 6928(h)) at the time at which an application for a grant or loan concerning the facility is submitted under this section;

''(D) a land disposal unit with respect to which—

''(i) a closure notification under subtitle C of the Solid Waste Disposal Act (42 U.S.C. 6921 et seq.) has been submitted; and

''(ii) closure requirements have been specified in a closure plan or permit;

''(E) a facility with respect to which an administrative order on consent or judicial consent decree requiring cleanup has been entered into by the United States under this Act, the Solid Waste Disposal Act (42 U.S.C. 6901 et seq.), the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), the Toxic Substances Control Act (15 U.S.C. 2601 et seq.), or the Safe Drinking Water Act (42 U.S.C. 300f et seq.);

''(F) a facility that is owned or operated by a department, agency, or instrumentality of the United States; or

''(G) a portion of a facility, for which portion, assistance for response activity has been obtained under subtitle I of the Solid Waste Disposal Act (42 U.S.C. 6991 et seq.) from the Leaking Underground Storage Tank Trust Fund established under section 9508 of the Internal Revenue Code of 1986.

''(b) MAINTENANCE OF BROWNFIELD PROGRAM.—The Administrator shall maintain the brownfield program established by the Administrator before the date of enactment of this section.

''(c) ELEMENTS OF PROGRAM.—In conducting the brownfield program, the Administrator may—

''(1) expend funds to identify and examine idle or underused industrial and commercial facilities for inclusion in the brownfield program; and

''(2) provide grants to State and local governments to clean up brownfields and return brownfields to productive use.

''(d) MAXIMUM GRANT AMOUNT.—A grant under subsection (c) shall not exceed $200,000 with respect to any brownfield facility.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated out of the Hazardous Substance Superfund to carry out this section—

''(1) $50,000,000 for fiscal year 1998;

''(2) $55,000,000 for fiscal year 1999; and

''(3) $60,000,000 for fiscal year 2000.''.

By Mr. SPECTER:

S. 24. A bill to provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes; to the Committee on Finance.

HEALTH CARE ASSURANCE ACT OF 1997

Mr. SPECTER. Mr. President, the start of the 105th Congress gives those of us in the Senate and the House a new opportunity to make a real difference in the lives of the American people. It is a chance for us to learn from the past concerning how to best respond to the challenges that are before us and forge important alliances to enable us to pass legislation that is important to the American people. One of our first priorities must be additional reforms of our Nation's health care system.

In the 104th Congress, I was pleased to cosponsor the Health Insurance Portability and Accountability Act of 1996, better known as the Kassebaum-Kennedy bill (S. 1028). There is no question that Kassebaum-Kennedy made significant steps forward in addressing troubling issues in health care. The bill's incremental approach to health care reform is what allowed it to generate consensus support in the Senate; we knew that it did not address every single problem in the health care delivery system, but it would make life better for millions of American men, women, and children.

There is much more that needs to be done. Accordingly, today I am introducing the Health Care Assurance Act of 1997, which, if enacted, will take us further down the path of incremental reforms started by Kassebaum-Kennedy. It is my firm belief that the best approach to addressing our Nation's health care problems is to enact reforms that improve upon our current market based health care system without completely overhauling our current system. My bill is intended to initiate and stimulate discussion in order to move the health care reform debate forward. I welcome any suggestions my colleagues may have concerning how the bill can be improved, as long as such suggestions are consistent with the incremental approach to reform that has proven to be the only way to obtain successful health care reform.

I want to note at the outset that through a State-run voucher system, my legislation would address health care coverage for the first time for the vast majority of the 10 million American children who lack health care insurance today. My proposal is compassionate and efficient and will preserve patient choice as its hallmark.

THE NEED FOR A BIPARTISAN APPROACH

Given the importance of succeeding in enacting this type of legislation, it is worth reviewing recent history. In particular, the debate over President Clinton's Health Security Act during the 103d Congress is replete with lessons concerning the pitfalls and obstacles that inevitably lead to legislative failure. Several times during the 103d Congress, I spoke on the Senate floor to address what seemed obvious to me to be the wisest course—to pass incremental health care reforms with which we could all agree. Unfortunately, what seemed obvious to me, based on comments and suggestions by a majority of Senators who favored a moderate approach, was not obvious at the time to the Senate's Democratic leadership.

This failure to understand the merits of an incremental approach was demonstrated during my attempts in April 1993 to offer a health care reform amendment based on the text of S. 631, an incremental reform bill I had introduced earlier in the session incorporating moderate, consensus principles. First, I attempted to offer the bill as an amendment to debt ceiling legislation. Subsequently, I was informed that the consideration of this bill would be structured in a way that my offering an amendment would be impossible. Therefore, I prepared to offer my health care bill as an amendment to the fiscal year 1993 emergency supplemental appropriations bill. The majority leader, Senator Mitchell, and Senator BYRD worked together to ensure that I could not offer my amendment by keeping the Senate in a quorum call, a parliamentary tactic used to delay and obstruct. I was unable to obtain unanimous consent to end the quorum call, and thus could not proceed with my amendment.

Three years later, well after the behemoth Clinton health care reform bill was derailed, the Senate once again endured a lengthy political battle concerning the Kassebaum-Kennedy bill. We achieved a breakthrough in August 1996, when enough Senators sensed the growing frustration of the American people and finally passed health care insurance market reforms such as increased portability. I would note that the final version of the Health Insurance Portability and Accountability Act of 1996 contained many elements which were in S. 18, the incremental health care reform bill I had introduced when the 104th session of Congress began on January 4, 1995.

In retrospect, I urge my colleagues to note a most important fact—the Kassebaum-Kennedy bill was enacted only after the most liberal Democrats abandoned their hopes for passing a nationalized, big government health care scheme, and the most conservative Republicans abandoned their position that access to health care is really not a major problem in the United States demanding Federal action.

Although we succeeded in enacting incremental insurance market reforms,

there is still much we need to do to improve our health care system. Additional reforms must be enacted if we are serious about our commitment to meet the needs of the American people. The bill I am introducing today is an updated version of the proposals I have introduced in the 102d, 103d, and 104th Congresses. I am hopeful that my colleagues understand how important it is to our constituents that we continue to reform the health care system. Looking back at our success with the Kassebaum-Kennedy bill, I am equally hopeful that my colleagues have come to realize that if we are to continue to be successful in meeting our constituents' needs, the solutions to our Nation's health care problems must come from the political center, not from the extremes.

Mr. President, there is no time to waste. Many of our Nation's health care problems are getting worse, not better. There is as much need now as ever before to correct the problems in our health care system for the 40.3 million or 17.4 percent of Americans for whom the system is not working. This is a group which, according to the Census Bureau, contained 900,000 more uninsured individuals in 1995 than the previous year. As I have said many times, we can fix the problem for these 40.3 million Americans without resorting to big government and turning the best health care system in the world, serving 82.6 percent of all Americans, on its head. The recent November elections reaffirmed the basic principle of limited government. Limited government, however, does not mean an uncaring or do-nothing government. Consistent with this principle, my legislation will fix the problem for many of the uninsured and underinsured while leaving intact what already works for those Americans with health insurance coverage.

To be sure, health care reform remains a very complex issue for Congress to address. But it is not so complex that we cannot act now and in a bipartisan way. As many of my colleagues will recall, in 1990 Congress passed Clean Air Act amendments that many said could not be achieved. That issue was brought to the Senate floor, and task forces were formed which took up the complex question of sulfuric acid in the air. We targeted the removal of 10 million tons in a year. We made significant changes in industrial pollution and in tailpipe emissions. We produced a balanced bill which protected the environment and retained jobs. Last year's enactment of Kassebaum-Kennedy is another example of such bipartisan success.

PREVIOUS EFFORTS ON REFORMING THE HEALTH CARE SYSTEM

I have advocated health care reform in one form or another throughout my 16 years in the Senate. My strong interest in health care dates back to my first term, when I sponsored the Health Care Cost Containment Act of 1983, S. 2051, which would have granted a limited antitrust exemption to health insurers, permitting them to engage in certain joint activities such as acquiring or processing information, and collecting and distributing insurance claims for health care services aimed at curtailing then escalating health care costs. In 1985, I introduced the Community Based Disease Prevention and Health Promotion Projects Act of 1985, S. 1873, directed at reducing the human tragedy of low birth weight babies and infant mortality. Since 1983, I have introduced and cosponsored numerous other bills concerning health care in our country. A complete list of the 21 health care bills that I have sponsored since 1983 is included for the RECORD.

During the 102d Congress, I pressed the Senate to take action on this issue. On July 29, 1992, I offered a health care amendment to legislation then pending on the Senate floor. This amendment included provisions from legislation introduced by Senator CHAFEE, which I cosponsored and which was previously proposed by Senators Bentsen and Durenberger. The amendment included a change from 25-percent to 100-percent deductibility for health insurance purchased by self-employed persons and small business insurance market reform to make health coverage more affordable for small businesses. When then-Majority Leader George Mitchell argued that the health care amendment I was proposing did not belong on that bill, I offered to withdraw the amendment if he would set a date certain to take up health care, just as product liability legislation had been placed on the calendar for September 8, 1992. The Majority Leader rejected that suggestion and the Senate did not consider comprehensive health care legislation during the balance of the 102d Congress. My July 29, 1992, amendment was defeated on a procedural motion by a vote of 35 to 60, along party lines.

The substance of that amendment, however, was adopted later by the Senate on September 23, 1992, when it was included in an amendment to broader tax legislation (H.R. 11), offered by Senators Bentsen and Durenberger and which I cosponsored. This amendment, which included substantially the same self-employed deductibility and small group reforms that I had proposed on July 29, passed the Senate by voice vote. Unfortunately, these provisions were later dropped from H.R. 11 in the House-Senate conference. It is worth noting for the RECORD that on January 23, 1994, when Senator Mitchell was asked on the television program ''Face The Nation'' about Senator Bentsen's bill from 1992, he stated that President Bush vetoed that provision as part of a broader bill. In fact, the legislation sent to President Bush never included that provision.

On August 12, 1992, I introduced legislation entitled the Health Care Affordability and Quality Improvement Act of 1992, S. 3176, that would have enhanced informed individual choice regarding health care services by providing certain information to health care recipients, lowered the cost of health care through use of the most appropriate provider, and improved the quality of health care.

On January 21, 1993, the first day of the 103d Congress, I introduced the Comprehensive Health Care Act of 1993, S. 18. This legislation was comprised of reform initiatives that our health care system could have adopted immediately. These reforms would have both improved access and affordability of insurance coverage and would have implemented systemic changes to lower the escalating cost of care in this country. S. 18, which is the principal basis of the legislation I am introducing today, melded the two health care reform bills I introduced and the one bill that I cosponsored in the 102d Congress, and contained several new provisions.

On March 23, 1993, I introduced the Comprehensive Access and Affordability Health Care Act of 1993, S. 631, which was a composite of health care legislation introduced by Senators COHEN, KASSEBAUM, BOND, and MCCAIN, as well as my bill, S. 18. I introduced this legislation in an attempt to move ahead on the consideration of health care legislation and provide a critical mass as a starting point. As I noted earlier, I was precluded by Majority Leader Mitchell from obtaining Senate consideration of my legislation as a floor amendment on several occasions. Finally, on April 28, 1993, I offered the text of S. 631 as an amendment to the pending Department of Environment Act (S. 171) in an attempt to urge the Senate to act on health care reform. My amendment was defeated 65 to 33 on a procedural motion, but the Senate had finally been forced to contemplate action on health care reform.

On the first day of the 104th Congress, January 4, 1995, I introduced a slightly modified version of S. 18, the Health Care Assurance Act of 1995 (also S. 18), which contained provisions similar to those ultimately enacted in Kassebaum-Kennedy, including insurance market reforms, an extension of the tax deductibility of health insurance for the self employed, and deductibility of long term care insurance for employers.

In total, I have taken to this floor on 16 occasions over the past 4 years to urge the Senate to address health care reform and on two occasions, I offered health care reform amendments which were voted on by the Senate.

As my colleagues are aware, I can personally report on the miracles of modern medicine. Three years ago, an MRI detected a benign tumor (meningioma) at the outer edge of my brain. It was removed by conventional surgery, with five days of hospitalization and five more weeks of recuperation.

When a small regrowth was detected by a follow-up MRI in June 1996, it was treated with high powered radiation from the ''Gamma Knife.'' I entered the

hospital in the morning of October 11 and left the same afternoon, ready to resume my regular schedule. Like the MRI, the Gamma Knife is a recent invention, coming into widespread use in the past decade. I ask unanimous consent to insert in the RECORD an article from the Pittsburgh Post-Gazzette about my experience with the Gamma Knife as well as an essay I wrote for several Pennsylvania newspapers on this subject.

My own experience as a patient has given me deeper insights into the American health care system beyond the U.S. Senate hearings where I preside as chairman of the Appropriations Subcommittee with jurisdiction over the Department of Health and Human Services. I have learned: First, our health care system, the best in the world, is worth every cent we pay for it; second, patients sometimes have to press their own cases beyond the doctors' standard advice; third, greater flexibility must be provided on testing and treatment; fourth, our system has the resources to treat the 39 million Americans not now covered, but we must find the way to pay for it; and fifth, all Americans deserve the access to health care from which I and others with coverage have benefited.

I share the American people's frustration with government and their desire to have the problems addressed. Over the past four years, I believe we have learned a great deal about our health care system and what the American people are willing to accept from the Federal Government. The message we heard loudest was that Americans did not want a massive overhaul of the health care system. Instead, our constituents want Congress to proceed more slowly and to target what isn't working in the health care system while leaving in place what is working.

THE CLINTON HEALTH PLAN

As I have said both publicly and privately, I am willing to cooperate with President Clinton in solving the problems facing our country. However, in the past I have found many important areas where I differed with the President's approach and I did so because I believed that they were proposals that would have been deleterious to my fellow Pennsylvanians, to the American people, and to our health care system. Most importantly, I did not support creating a large new government bureaucracy because I believe that savings should go to health care services and not bureaucracies.

On this latter issue, I first became concerned about the potential growth in bureaucracy in September 1993 after reading the President's 239-page preliminary health care reform proposal. I was surprised by the number of new boards, agencies, and commissions, so I asked my legislative assistant to make me a list of all of them. Instead, she decided to make a chart. The initial chart depicted 77 new entities and 54 existing entities with new or additional responsibilities.

When the President's 1,342-page Health Security Act was transmitted to Congress on October 27, 1993, my staff reviewed it and found an increase to 105 new agencies, boards, and commissions and 47 existing departments, programs, and agencies with new or expanded jobs. This chart received national attention after being used by Senator Bob Dole in his response to the President's State of the Union Address on January 24, 1994.

The response to the chart was tremendous, with more than 12,000 people from across the country contacting my office for a copy. Numerous groups and associations, such as United We Stand America, the American Small Business Association, the National Federation of Republican Women, and the Christian Coalition, reprinted the chart in their publications—amounting to hundreds of thousands more in distribution. Bob Woodward of the Washington Post later stated that he thought the chart was the single biggest factor contributing to the demise of the Clinton health care plan. And, as recently as the November 1996 election, my chart was used by Senator Dole in his Presidential campaign to illustrate the need for incremental health care reform as opposed to a big government solution.

COMPONENTS OF THE HEALTH CARE ASSURANCE ACT OF 1997

As I begin to describe my new proposal, the Health Care Assurance Act of 1997, in greater detail, I want to reiterate that in creating solutions, it is imperative that we do not adversely affect the many positive aspects of our health care system which works for 82.6 percent of all Americans. It is more prudent to implement targeted reforms and then act later to improve upon what we have done. I call this trial and modification. We must be careful not to damage the positive aspects of our health care system upon which more than 224 million Americans justifiably rely.

The legislation I am introducing today has three objectives: First, to provide affordable health insurance for the 40.3 million Americans now not covered; second, to reduce health care costs for all Americans; and (3) to improve coverage for underinsured individuals and families. This legislation is comprised of initiatives that our health care system can readily adopt in order to meet these objectives, and it does not create an enormous new bureaucracy to meet them.

This bill builds and improves upon provisions put forth in my legislation from the 104th Congress, S. 18. That legislation included provisions to encourage the formation of small group purchasing arrangements, increase access to prenatal care and outreach for the prevention of low birth weight babies, facilitate the implementation of patients' rights regarding medical care at the end of life, improve health education, place greater emphasis on and expanded access to primary and preventive health services, utilize nonphysician providers, reform the COBRA law to extend the time period for employees who leave their jobs to maintain their health benefits until alternative coverage becomes available, and increase the availability and use of consumer information and outcomes research.

This year, I have added a new title I to provide vouchers to cover children who lack health insurance coverage. Preliminary data from the Census Bureau shows that in 1995, there were 10 million uninsured Americans under the age of 18 in the United States, representing 14 percent of all children. According to a July, 1996, General Accounting Office report, this vulnerable population reached an all time high number of uninsured in 1994. The number of children without health insurance coverage was greater in 1994 than any other time in the last 8 years. This is partly because the proportion of children with private insurance is decreasing as companies increasingly are covering only workers and not their spouses and children.

Children are our Nation's greatest resource and our most vulnerable population, along with our Nation's seniors. In 1965, we ensured that our Nation's seniors would have access to health care. In 1997, we should do no less for our Nation's children.

My approach is to give minimum federal directives and leave it to the States to determine how this health coverage would be delivered. The size of the benefits package would be keyed to the average cost in each State of providing insurance coverage for three basic types of services: First, preventive care; second, primary care; and third, acute care services. Full Federal subsidies would be provided to uninsured children living in families with incomes up to 185 percent of the poverty line. On average, a family of four living at 185 percent of the poverty level lives on $28,860 a year. Partial subsidies would be provided to uninsured children living in families with incomes between 185 and 235 percent of the poverty line. On average, a family of four living at 235 percent of the poverty level lives on $36,660 a year. Under this plan, more than 7.5 million children or 77 percent of all uninsured children would receive health care coverage.

The subsidy levels in my plan are modeled after our excellent programs in Pennsylvania that provide health care for needy children. A unique public-private partnership has enabled approximately 60,000 children to receive basic health care coverage under one of two programs: The Children's Health Insurance Program of Pennsylvania and the Caring Program for Children sponsored by Highmark Blue Cross/Blue Shield and Independence Blue Cross.

States have traditionally been the great laboratories for experimentation. Accordingly, I leave it to the States to work out the detail on how this program should be run. My hope is that

the subsidy program will be so successful it will be used as a model for reform of the Medicaid program. Savings through other health care reforms detailed later in this statement will provide the funds needed to implement the essential effort to take care of the health of our Nation's children.

I have also added a new title VIII to establish a national fund for health research within the Department of Treasury. This fund will supplement the moneys appropriated for the National Institutes of Health. It is to be on budget, but the financing mechanism is not specified. This proposal was first developed by my distinguished colleagues, Senators Mark Hatfield and TOM HARKIN. Senator Hatfield, who retired after the 104th Congress, worked closely with me on medical research funding issues. The concept of a national fund for health research was incorporated into the National Institutes of Health Revitalization Act of 1996, which was passed by the Senate, but not by the House.

Responding to decreases in discretionary funding, in the 104th Congress, Senators Hatfield and HARKIN introduced S. 1251, the National Fund for Health Research Act. They wisely anticipated that we cannot continue to look solely to the appropriations process for the necessary resources to sustain sufficient growth in biomedical research. The great advancements made by the United States in biomedical research are part of what makes this country among the best in the world when it comes to medical care. Their idea is a sound one and ought to be adopted. I look forward to working together with Senator HARKIN to enact a biomedical research fund this Congress.

Taken together, I believe the reforms proposed in this bill will both improve the quality of health care delivery and will bring down the escalating costs of health care in this country. These proposals represent a blueprint which can be modified, improved and expanded. In total, I believe this bill can significantly reduce the number of uninsured Americans, improve the affordability of care, ensure the portability and security of coverage between jobs, and yield cost savings of billions of dollars to the Federal Government, which can be used to cover the remaining uninsured and underinsured Americans.

INCREASING COVERAGE

According to the U.S. Bureau of the Census, in 1995, 224 million Americans derived their health insurance coverage as follows: approximately 64 percent from employer plans; 14.3 percent from Medicare and Medicaid; 4 percent from other public sources; and about 7 percent from other private insurance. However, 40.3 million people were not covered by any type of health insurance.

Statistics from the Employment Benefit Research Institute November 1996 show that small businesses generally provide less health insurance coverage than larger businesses or the public sector. About 73 percent of employees in the public sector are provided with health insurance; while 55.5 percent of employees in the private sector are covered. Both levels are far higher than businesses with fewer than 10 employees (25.8%); with 10 to 24 employees (38.8%); or with 25 to 99 employees (54.4%).

As I mentioned previously, title I of the bill gives federal subsidies to provide health care coverage for our Nation's children. Early estimates are that the total cost of these vouchers will be approximately $24 billion over 5 years. This $24 billion is a worthwhile investment because it will mean healthier children and substantially reduced anxiety for millions of parents who cannot afford to pay for needed medical care for their children.

Title II contains provisions to make it easier for small businesses to buy health insurance for their workers by establishing voluntary purchasing groups. It also obligates employers to offer, but not pay for, at least two health insurance plans that protect individual freedom of choice and that meet a standard minimum benefits package. It extends COBRA benefits and coverage options to provide portability and security of affordable coverage between jobs. While it is not possible to predict with certainty how many additional Americans will be covered as a result of the reforms in title II, a reasonable expectation would be that these reforms will cover approximately 10 million Americans. This estimate encompasses the provisions included in title II which I will discuss in further detail.

Specifically, title II extends the COBRA benefit option from 18 months to 24 months. COBRA refers to a measure which was enacted in 1985 as part of the Consolidated Omnibus Budget Reconciliation Act [COBRA '85] to allow employees who leave their job, either through a layoff or by choice, to continue receiving their health care benefits by paying the full cost of such coverage. By extending this option, such unemployed persons will have enhanced coverage options.

In addition, options under COBRA are expanded to include plans with lower premiums and higher deductibles of either $1,000 or $3,000. This provision is incorporated from legislation introduced in the 103d Congress by Senator PHIL GRAMM and will provide an extra cushion of coverage options for people in transition. According to Senator GRAMM, with these options, the typical monthly premium paid for a family of four would drop by as much as 20 percent when switching to a $1,000 deductible and as much as 52 percent when switching to a $3,000 deductible.

With respect to the uninsured and underinsured, my bill would permit individuals and families to purchase guaranteed, comprehensive health coverage through purchasing groups. Health insurance plans offered through the purchasing groups would be required to meet basic, comprehensive standards with respect to benefits. Such benefits must include a variation of benefits permitted among actuarially equivalent plans to be developed by the National Association of Insurance Commissioners. The standard plan would consist of the following services when medically necessary or appropriate: First, Medical and surgical devices; second, medical equipment; third preventive services; and fourth, emergency transportation in frontier areas. It is estimated that for businesses with fewer than 50 employees, voluntary purchasing cooperatives such as those included in my legislation could cover up to 10 million people who are currently uninsured.

My bill would also create individual health insurance purchasing groups for individuals wishing to purchase health insurance on their own. In today's market, such individuals often face a market where coverage options are not affordable. Purchasing groups will allow small businesses and individuals to buy coverage by pooling together within purchasing groups, and choose from among insurance plans that provide comprehensive benefits, with guaranteed enrollment and renewability, and equal pricing through community rating adjusted by age and family size. Community rating will assure that no one small business or individual will be singularly priced out of being able to buy comprehensive health coverage because of health status. With community rating, a small group of individuals and businesses can join together, spread the risk, and have the same purchasing power that larger companies have today.

For example, Pennsylvania has the ninth lowest rate of uninsured in the Nation, with 90 percent of all Pennsylvanians enrolled in some form of health coverage. Lewin and Associates found that one of the factors enabling Pennsylvania to achieve this low rate of uninsured persons is that Pennsylvania's Blue Cross-Blue Shield plans provide guaranteed enrollment and renewability, an open enrollment period, community rating, and coverage for persons with preexisting conditions. My legislation seeks to enact reforms to provide for more of these types of practices. The purchasing groups, as developed and administered on a local level, will provide small businesses and all individuals with affordable health coverage options.

Unique barriers to coverage exist in both rural and urban medically underserved areas. Within my State of Pennsylvania, such barriers result from a lack of health care providers in rural areas, and other problems associated with the lack of coverage for indigent populations living in inner cities. This bill improves access to health care services for these populations by: First, Expanding Public Health Service programs and training more primary care